

Testimony to the Human Services Committee

Regarding: HB 5355 AAC An Advanced Dental Hygiene Practice Pilot Program

Monday, March 1, 2010

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Senator Doyle, Representative Walker and Members of the Human Services Committee,
ADHP Curriculum

The ADHP master's degree curriculum allows for the acquisition of competencies that build upon the fundamental knowledge and skills achieved at the baccalaureate level.

As Dean of the University of Bridgeport – Fones School of Dental Hygiene, I can assure you we are fully committed to developing and implementing a Master's Degree program that will educate and graduate licensed and qualified candidates for this mid-level oral health practitioner. The ADHP curriculum will prepare practitioners to address special oral health needs of priority populations including children, elderly, adults, and those with special needs who will be served in public health settings. The ADHP will be a new member of the oral health team who will work in collaboration with dentists, to offer more complete array of dental services to more CT residents.

When it comes to the educational program in support of patient services, the ADHP educational framework is similar to that of a dental curriculum in areas where similarities occur, thereby providing comparable patient and public safety.

The implementation of a pilot program requires baseline statistics and post statistics. All required statistics will measure the degree of success of the pilot program. The expected length of the pilot program is 18 months with a start date in 2012.

The American Dental Association biennially publishes a report devoted to the instruction, laboratory, and patient care activities at all 56 United States dental schools. Utilizing data obtained from the most recent 2007 Survey of Dental Education, the following comparisons between dental school and ADHP clock hours is noted.

Average Clock Hours	Dental School	ADHP	Difference from ADHP
Dental Clinical Sciences	3,557	3,237	-320
Community Based Patient Care	132	400	+268
General and Oral Pathology	198	201	+3
Periodontics	301	314	+13
Pharmacology	85	102	+17
Oral Diagnosis and Treatment Planning	202	111	-91
Dental Public Health and Special Needs	121	253	+132
Dental Emergencies	70	62	-8
Anesthesiology/Pain Control	57	54	-3

As can be seen, the difference between the two curricula is minimal based on each professional's scope of practice. The ADHP curriculum fully prepares the practitioner to perform what is required of the position. This comparison of educational clock hours demonstrates that the practitioner is fully educated in didactic, laboratory, and clinical sciences required to achieve the appropriate competency level.

Statistical Surveys Performed

Numerous surveys were performed within the past three years in regards to the need and interest of the ADHP. These surveys are addressed later in my testimony. What the information gathered in those surveys show is that both dentists and dental hygienists see a need for the ADHP and support this new member of the dental team. While there is an interest among some Connecticut dental hygienists to become an ADHP, others prefer to maintain their position as a registered dental hygienist. The following results are based on three quantitative research studies.

More specifically, one research study involved a sample of 250 dentists and dental hygienists. Of those surveyed 83.2% agreed that access to dental care is a significant concern, 14% somewhat agreed, 1.6% were neutral, 1.2% somewhat agreed, and 0% strongly disagreed. When respondents were asked if the profession of dentistry was able to address access to care needs without additional provider designations 12.8% strongly agreed, 15.2% somewhat agreed, 12.4% were neutral, 20.4% somewhat disagreed and 39.2% strongly disagreed. That is, only 28% thought the current licensing structure of the dental profession was capable of delivering needed access to dental care. When asked if they support the development of the proposed ADHP legislation, 70.4% said yes, 5.6% were neutral, 9.2% responded no, and 14.8% were unfamiliar.

Another research study ascertained the views and perceptions of Connecticut dental hygiene students in 2007. The sample included 98% of CT dental hygiene students. Results showed that 48% of the respondents view the future of ADHP as successful, 36% view it as somewhat successful, 89% perceive the current curriculum as providing the tools and knowledge necessary to provide oral care to the underserved, 69% consider advancing their education, and 26% consider pursuing a career in public health.

A third study included a sample of 140 dental hygienists. Of those surveyed, 90% are currently practicing as clinicians, 45% earned a BSDH, 37% an AS degree, and 15% a MSDH. 91% believe that there is a lack of preventive and restorative care for the un-served public and 56% would be willing to pursue the MSDH. In addition, 23% work in public health facilities, 47% are considering a career in public health and 31% speak more than one language.

While the dental needs citizens of CT may be reasonably served according to certain surveys, there is no reason we should not strive to improve the provision of dental care, especially access to care, for all.

The Advanced Dental Hygiene Practitioner (ADHP) and Access to Oral Health Care

Access to Oral Health Care in the United States

The access to care crisis that Americans face in obtaining quality health care services is not limited to medical care. Although oral health is integral to overall health, millions of Americans are not currently able to access oral health care services they need to maintain a healthy mouth and body.

Tooth decay, while almost completely preventable, is the nation's most common chronic disease among children—five times more common than asthma.¹ Children, the elderly, and the working poor are disproportionately affected by the access to oral health care crisis in the US.²

In 2000, the Surgeon General issued a landmark report, *Oral Health in America*, which identified the “silent epidemic” of oral health diseases and called on oral health stakeholders to improve the nation’s oral health.

Creating Solutions to the Access to Care Crisis

Dental hygienists play an important role on the oral health care team—preventing oral disease and treating it while it is still manageable which can save critical health care dollars in the long-run.

As one of the fastest growing occupations in the country,³ dental hygiene is outpacing the growth of the dental profession. An estimated 6,000 dentists retire annually while only 4,000 dental school graduates enter the workforce each year.⁴ These workforce realities come at a time when an estimated 108 million Americans lack dental insurance and over 2,000 Dental Health Professional Shortage Areas (DHPSAs) have been identified by the Health Resources and Services Administration.

State dental and dental hygiene associations in a number of states have worked to develop local solutions that maximize the existing oral health care workforce to facilitate greater access to care. Collaborative practice agreements (MN, NM), limited access permits (OR), and public health endorsements (NV, ME) are among some of the state efforts to facilitate direct access to preventive care administered by a dental hygienist.

ADHA is working to establish the **Advanced Dental Hygiene Practitioner (ADHP)** as a mid-level oral health care provider that will leverage the existing dental hygiene workforce to have an even greater impact on the delivery of care to those in need.

Why the Advanced Dental Hygiene Practitioner? Why Now?

Mid-level health care providers have proven effective and successful in a number of medical fields. As a mid-level oral health provider, the ADHP will serve in a capacity similar to that of the nurse practitioner in medicine. The ADHP will add a new member to the oral health care team and provide an additional point of entry into the oral health care system for those currently disenfranchised from the system.

A recent survey conducted by the National Association of Community Health Centers found that restorative and preventive services were the top two needed oral health services as identified by the Federally Qualified Health Centers (FQHCs) surveyed.⁵ The report also noted that “dentists remain in short supply and almost half of the rural (Community Health Center grantees have had vacant dentist positions for 7 or more months. ADHPs will be educated and licensed to provide both preventive and limited restorative services to meet identified patient needs. ADHPs will bring an increasing numbers of patients into the oral health care pipeline and make necessary referrals to dentists and other medical professionals, serving to strengthen the crucial link between the oral health, medical, and community networks.

The concept of mid-level providers in oral health is not new. Currently, more than 40 countries, including Canada, New Zealand, Australia, and the United Kingdom, allow mid-level practitioners to practice in oral health.

ADHP Education and Outreach
The ADHP will be a licensed dental hygienist educated at the Master’s degree level, the general academic standard for mid-level providers. In addition to the full range of dental hygiene clinical services, ADHPs will administer minimally invasive restorative services and will also have limited prescriptive authority. ADHPs will be educated in health promotion and disease prevention, provision of primary care, case and practice management, quality assurance, and ethics, which will provide a comprehensive approach to the delivery of oral healthcare services.

ADHPs will provide care in a variety of public health settings—schools, clinics, and long-term care facilities among others—to a diverse patient population. The ADHP model is a meaningful and substantive response to the call of the U.S. Surgeon General to increase access to oral health care services for the nation’s underserved.



1. *Oral Health in America: A Report of the Surgeon General*. US Surgeon General, 2000.
2. *Ibid.*
3. *Occupational Outlook Handbook*. US Bureau of Labor Statistics. 2008-2009 Edition.
4. *Recruitment and Retention of a Quality Workforce in Rural Areas*. National Rural Health Association, November 2006.
5. *Health Centers’ Role in Addressing the Oral Health Needs of the Medically Underserved*. National Association of Community Health Centers, August 2007.

National Recognition of the Need for the Advanced Dental Hygiene Practitioner

ADHP Timeline

2004

ADHA House of Delegates adopts policy to pursue the ADHP.

National Rural Health Association

"It is time to find a new way to deliver oral health care services; it is time to test the ADHP concept." January 2006

American Public Health Association's Oral Health Section

"The ADHP, a role comparable to the nurse practitioner, presents a timely and appropriate way to explore new approaches to oral health care delivery..." March 2006

National Rural Education Association

"NREA is excited about the prospect of an Advanced Dental Hygiene Practitioner." February 2006

National Media Outlets Address the Need for Change in the Oral Health Care Delivery System

The Washington Post

"At the heart of this issue is a lack of understanding of the importance and implications of good oral health care...every day there are children who can't pay attention in school and who can't fall asleep at night because they have problems with their teeth." July 13, 2007

The New York Times

"American children are dying because of a lack of access to health care...There are nine million children who lack health care in the U.S. and millions more who are eligible for coverage but fall through the cracks for one reason or another." June 12, 2007

"...the percentage of Americans with untreated cavities began rising this decade, reversing a half-century trend of improvement in dental health." October 11, 2007

"In a nation where a person's smile is considered a sign of general well-being and an important factor in landing a job, dental care is becoming ever more unequal..." December 28, 2004

2005
ADHA seeks funding to pilot test the ADHP.

Congress approves language encouraging the HRSA to "explore development of an advanced dental hygiene practitioner" as part of the report accompanying the FY 2006 HHS funding bill (Public Law 109-149).

ADHA convenes an advisory committee of 14 national organizations dedicated to increasing access to oral health services to provide input on the ADHP concept.

2006
ADHA stages Lobby Day where over 170 dental hygienists and dental hygiene students from across the United States travel to Washington DC to meet with legislators about the need for the ADHP.

2007
ADHA's president testifies before the House Appropriations Health Subcommittee about funding for oral health programs, including ADHP.

ADHA members conduct visits with members of Congress in state and district offices, encouraging pilot project funding.

2008
ADHA and its members continue efforts to secure funding for an ADHP pilot. Eastern Washington University in Spokane, Washington begins planning for an ADHP Masters education program.

ADHP educational competencies are finalized by ADHA's Board of Trustees in March.

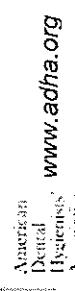
Minnesota passes legislation establishing the Oral Health Practitioner whose scope of would provide educational, preventive, therapeutic, diagnostic, and restorative oral health services, akin to the ADHP.

2009
Congress passes SCHIP reauthorization legislation including dental benefits and a provision directing the GAO to study the "feasibility and appropriateness of using qualified mid-level providers."

ICM convenes a workshop on the sufficiency of the dental workforce in the future where ADHP and other non-dentist providers are highlighted.

Minnesota passes first law in the country to allow for students educated under the ADHP model to become licensed to practice. First ADHP Master's program slated to begin at Metropolitan State University in fall 2009.

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